

The property tax allowance shall be a per patient per day amount for allowable property tax expense. Allowable property tax expense shall exclude any state property tax credit and any special assessments for capital improvements, such as sewers, water mains and pavements. Whenever exemptions to property tax are legally available, the provider shall be expected to pursue such exemptions. If the provider does not pursue available exemptions, the expenses incurred for property tax shall not be allowed.

2.420 Tax-Exempt Facilities

The property tax allowance for tax-exempt facilities may include a per patient per day amount for the cost of needed municipal services. Includable municipal services will be limited to those services which are financed through the municipality's property tax and which are provided by the municipality to property taxpayers without levying a special fee for the service. A tax-exempt facility may be paying a municipal service fee to the municipality for the services or may provide the service and incur the cost in their own operation.

2.500 PROPERTY PAYMENT ALLOWANCE

The property payment allowance will be a per patient day amount based upon the value of a facility's buildings as estimated by a commercial estimator, target amounts based on service factors established by the Department, and the nursing home's allowable property-related expenses. The estimation will conform with guidelines determined by the Department. This allowance covers, in whole or in part, the nursing home's expenses related to ownership and/or rental of the land, land improvements, buildings, fixed and movable equipment, and other physical assets.

2.600 OVER-THE-COUNTER DRUG ALLOWANCE

The Department will reimburse for nonprescription charges approved by the Department through an over-the-counter drug allowance which recognizes the allowable expenses to provide certain over-the-counter drugs, ordered by a physician, to Wisconsin Medicaid nursing home residents up to amounts payable under Section 3.600. The allowable expenses may include the average wholesale price of the drugs and any pharmacy dispensing costs. Pharmacy dispensing costs shall not exceed 50% of the pharmacy's average wholesale price of the drug.

2.700 PROVIDER INCENTIVES

2.710 Exceptional Medicaid/Medicare Utilization Incentive

Nursing homes, other than those operated by a governmental entity, with exceptional Medicaid/Medicare utilization, described in Section 3.651, may receive the payment incentive. A non-profit corporation operating a facility, which in turn is controlled exclusively by a municipality, will be viewed as a government entity. The primary source of ownership information is the owner identified on the operating license issued by the Department. Ownership status is determined as of the last day of the cost report. If a governmental facility changes ownership status, it will not be eligible for this incentive until such time that the change in ownership status has been reflected on the cost report used to set the rate for the applicable rate year.

2.720 Private Room Incentive

Nursing homes may be eligible to receive a Basic Private Room Incentive (BPRI), a Renovation Private Room Incentive (RPRI) or a Replacement Private Room Incentive (RPPRI). To determine eligibility, nursing homes must meet licensed bed and patient day requirements. To receive an incentive, nursing homes must submit an affidavit to the department during the reimbursement year stating that they will not charge Medicaid residents the surcharge for private rooms allowed under HFS 105.09(4)(k) as of the date the incentive would be effective. A private room is a room licensed for single occupancy.

1. Basic Private Room Incentive. Nursing homes which meet the both exceptional Medicaid/Medicare utilization, see Plan section 2.710, and have an extraordinary number of private rooms equal to the private room percentage (PRP) listed in Plan section 3.653(a), may receive a payment incentive. This Basic Private Room Incentive is based on the percentage of private rooms to total licensed beds. Licensed bed and private room requirements are listed in Plan section 3.653(a).
2. The Renovation Private Room Incentive (RPRI) is for facilities that undergo substantial renovation for the sole purpose of converting existing space into single rooms subsequent to 7/1/2000. For purposes of this section, substantial means the cost of the renovation project must be at least 25% of the total Undepreciated Replacement Cost, as defined in Plan section 3.531 (b). The RPRI for renovated facilities will be effective the first day of the month following completion of the renovation or 7/1/2002 whichever is later. The facility must meet the exceptional Medicaid/Medicare utilization in Plan section 2.710 and the private room percentage (PRP) listed in Plan section 3.653(b) after the renovation is complete.
3. The Replacement Private Room Incentive (RPPRI) is for facilities replacing 100% of the patient rooms subsequent to 7/1/2000, and will be effective the first day of service in the replacement facility or 7/1/2002 whichever is later. The replacement facility must meet the exceptional Medicaid/Medicare utilization in Plan section 2.710 and the private room percentage (PRP) listed in Plan section 3.653(b). If a facility does not replace 100% of the patient rooms they may still qualify for the RPRI or BPRI.

2.730 Energy Savings Incentive

If a facility completes a remodeling or renovation project specifically designed to reduce consumption of electricity or heating fuels, or to reduce their electricity or heating fuel rates per unit of energy, the facility may receive an incentive per the calculation method in Section 3.652. In order to qualify for this incentive, the project must have been approved in advance by the Department. During the approval process the Department will consider:

- a. The projected savings from the project based on an independent analysis to be provided by the facility. Such analysis may be provided by a public utility or an independent contractor qualified in engineering, architecture, or energy audits.
- b. The projected cost of the project.
- c. The combined simple payback for all projects proposed for the facility must be less than ten years.

Allowable costs for the incentive will be the lower of: 1) the amount approved in advance by the Department, or 2) the cost of equipment, installation, engineering, energy management and consultant fees prior to rebates. Interest, bond discounts, premiums and financial and/or auditing fees will not be an allowable cost for the incentive.

Replacement boilers that are not part of a co-generation project, replacement central air conditioners, condensers and windows, if included in a project approved or started after 7/1/2000, are excluded from this incentive, although fuel conversion projects are valid projects for this incentive.

SECTION 3.000 CALCULATION OF PAYMENT ALLOWANCES

3.001 Introduction

The payment allowance calculations are described in this section. For the payment system, the calculations of the allowances are on a per patient day basis. The patient days may be adjusted for minimum occupancy.

3.010 The Minimum Occupancy Standard

The minimum occupancy standard is 90.5%, except for traumatic head injury units.

3.020 Adjusted Patient Day

The term "adjusted patient days" means patient days, including therapeutic and hospitalization bed hold days, as reduced to recognize the 15% reduction on the payment rate for bed hold days and other adjustments determined by the Department. For example, 1000 patient days, including 100 bed hold days, would be reduced by 15 days (i.e. 15% x 100) to 985 adjusted patient days.

3.030 Minimum Occupancy Factor

The nursing home occupancy is determined by the adjusted patient days in Section 3.020 divided by the available bed days (beds for rate setting in Section 3.040 multiplied by the days in the cost reporting period). If the nursing home occupancy is equal to or greater than the occupancy standard, the minimum occupancy factor (Min) is 1.0.

If the nursing home occupancy is less than the occupancy standard in section 3.010, the minimum occupancy factor is:

Min = Minimum occupancy factor
 Ratio = The ratio of the actual nursing home occupancy to the minimum occupancy standard

Min = (0.50 * Ratio) + 0.50

3.031 Minimum Occupancy Standard for Traumatic Head Injury Units

A minimum occupancy standard of 50.0% will be applied to the rate set for traumatic head injury units in Section 4.692.

3.040 Beds for Rate Setting

The beds for rate setting will be calculated as follows:

- Licensed beds on the last day of the base cost reporting period in section 1.302;
- Less the beds in the bed bank on the last day of the base cost reporting period in section 1.302;
- Less any additional beds deposited after the close of the base cost reporting period in section 1.302 but before July 1, 2002.

3.050 Adjustments

1. If a free-standing ICF-MR facility has decreased its use of unrestricted licensed beds by the lesser of 10 beds or 10%, the facility may request that the reduced number of beds to be used in calculating the patient days at minimum occupancy (Section 3.030). Any resulting rate change is to be effective the first of the month following the decrease in licensed beds.
2. Restricted use beds with a restricted use license issued before July 1, 1995 will be excluded from the beds for rate setting.
3. Beds that are part of RAP projects, as defined in Section 1.240, will be excluded from Beds for Rate Setting if the project(s) is completed by July 1, 2000.
4. Facilities that have qualified for a Section 4.800 adjustment relating to beds out-of-use for renovation projects shall also qualify for a reduction to beds for rate setting. The reduction shall be equal to the monthly weighted average of the beds out-of-use during the cost report period used for rate setting.

3.060 Bed Bank

The Department shall exclude banked nursing home beds from the beds for rate setting (Section 3.040).

For bed bank requests submitted after June 30, 2002, the bed adjustment will be effective July 1, 2003, subject to the Methods then in effect.

If a bed license is split after the end of the cost report period, causing a transfer of beds between more than one facility and there are banked beds on the license, a new rate will be calculated for each facility, effective July 1, 2003, subject to the Methods then in effect, unless Sections 4.400 or 4.500 apply.

3.061 Bed Bank Reductions and Resumption

The Department shall allow the nursing home to exercise the right to resume use of banked beds, unless PERMANENTLY reduced by s. 49.45(6m), with licensure resumption contingent upon receipt of a 18 month prior notice to the Department. Permanent reduction shall occur if any banked beds remain delicensed under this paragraph at the rate of 10% of all remaining delicensed banked beds or 25% of one bed, whichever is greater.

3.062 Bed Bank Restrictions

- a. If any of the provisions of Section 4.500 are being applied during the payment rate year to a facility that phases down or closes, then that facility does not qualify for banking of beds.
- b. The total beds for rate setting and banked beds cannot exceed the total licensed beds.
- c. Banked beds cannot be occupied by any resident. If such use is discovered and such use would raise the number of occupied beds above the number of licensed beds minus banked beds, all beds banked by the facility will be expunged from the bank and the banked beds will be delicensed permanently.

If such use is discovered but does not exceed the number of licensed beds minus banked beds, the facility has 30 days to correct the occupancy or the beds involved will be expunged from the bed bank and will be delicensed permanently.

- d. If banked beds are part of a phase down, the beds will be expunged from the bed bank.

3.070 Exclusions

If the facility has a total of 50 or less beds for rate setting (Section 3.040), including any distinct part ICF-MR or distinct part IMD units in the total facility, they are excluded from the minimum occupancy standard (Section 3.010).

3.100 DIRECT CARE ALLOWANCE**3.110 Types of Payment Rates**

The payment allowance for direct care will be computed for each facility so as to establish a rate for each of the following levels of care:

- (a) A skilled care rate (SNF).
- (b) An intense skilled nursing (ISN) rate.
- (c) An intermediate care rate (ICF 1).
- (d) A limited care rate (ICF 2).
- (e) A combined personal care rate (ICF 3) and residential care rate (ICF 4).
- (f) A developmentally disabled 1A rate (DD 1A).
- (g) A developmentally disabled 1B rate (DD 1B).
- (h) A developmentally disabled 2 rate (DD 2).
- (i) A developmentally disabled 3 rate (DD 3).

3.115 Patient Days

Adjusted patient days from the base cost reporting period (Section 3.020) shall be used in the calculation of the direct care allowance. Any patient days classified in a level of care greater than the facility is licensed to provide shall be reclassified downward to the highest level of care for which the facility is licensed. All Medicare adjusted patient days shall be classified as intensive skilled nursing days (ISN).

3.118 ICF-MR Facilities

A facility which has a distinct part certified as ICF-MR shall submit a combined cost report under Section 1.176. Payment rates shall be determined in a combined rate calculation which includes the ICF-MR distinct part and those NF distinct parts which are covered by the combined cost report. This combined calculation of rates shall apply even if each distinct part has a separate provider identification number.

3.120 Method of Computation of Direct Care Allowance

3.121 Inflation Adjusted Expense

The facility's actual allowable direct care expenses for staff wages, fringe benefits, purchased services and supplies shall be inflated/deflated from the cost reporting period to the common period using the inflation factors in Section 5.310. Dividing the sum of these inflated expenses by adjusted patient days yields per day inflated expenses.

3.122 Case Mix Index

The facility's Case Mix Index (CMI) is the average of the case mix values in Section 5.420 weighted by the adjusted patient days for each level.

The facility's CMI for Medicaid residents (CMI-T19) is the average of the case mix values in Section 5.420 weighted by the adjusted Medicaid patient days for each level.

3.125 Adjustment to Case Mix Index

Facilities that have beds for rate setting (Section 3.040) of fifty beds or less and are certified only as a nursing facility will have a twenty percent (20%) increase in their case mix index. Facilities that are certified as ICF-MR facilities either in whole or in part are not eligible to have its case mix index adjusted under this section.

3.126 Facility Direct Care Target

1. The facility's Direct Care Direct Services Target is the product of CMI times the Statewide Direct Care Direct Services Base in Section 5.430, times the Labor Factor in Section 5.410. Hence,

$$\text{Direct Care Direct Services Target (DST)} = \text{CMI} * \text{Statewide Direct Care Direct Services Base} * \text{Labor Factor}$$

2. The facility's Direct Care Supplies and Other Target is the product of CMI times the Direct Care Supplies and Other Base in Section 5.430. Hence,

$$\text{Direct Care Supplies and Other Target (SOT)} = \text{CMI} * \text{Direct Care Supplies and Other Base}$$

3.127 Direct Care Common Period Allowance

The facility's Direct Care Common Period Allowance consists of a Direct Care Direct Services Common Period Allowance and Direct Care Supplies and Other Common Period Allowance calculation.

1. The Direct Care Direct Services Common Period Allowance is defined by:

$$\begin{aligned} \text{PriCom} &= \text{Direct Services Direct Services Common Period Allowance} \\ E &= \text{Expense per patient day per 3.121} \\ \text{DST} &= \text{Direct Care Direct Services Target per 3.126 (1)} \\ \text{Min} &= \text{Minimum occupancy factor in section 3.030} \end{aligned}$$

If the expense (E) is equal to or greater than the target (DST),

$$\text{PriCom} = \text{DST} * \text{Min}$$

If the expense (E) is less than the target,

$$\text{PriCom} = E * \text{Min}$$

2. The Direct Care Supplies and Other Common Period Allowance is defined by:

$$\begin{aligned} \text{SplyCom} &= \text{Direct Care Supplies and Other Common Period Allowance} \\ E &= \text{Expense per patient day per 3.121} \\ \text{SOT} &= \text{Direct Care Supplies and Other Target per 3.126 (2)} \\ \text{Min} &= \text{Minimum occupancy factor in section 3.030} \end{aligned}$$

If the expense (E) is equal to or greater than the target,

$$\text{SplyCom} = \text{SOT} * \text{Min}$$

If the expense (E) is less than the target,

$$\text{SplyCom} = [E + .5(\text{SOT} - E)] * \text{Min}$$

3.128 Direct Care Reimbursement Period Allowance

1. The Direct Care Direct Services inflation increment is the facility's CMI times the Statewide Direct Care Direct Services Inflation Increment in Section 5.440.

Direct Care Direct Services Inflation Increment = CMI * Statewide Direct Care Direct Services Inflation Increment

Direct Care Direct Services Reimbursement Period Allowance = Direct Care Direct Services Common Period Allowance (PriCom) + Direct Care Direct Services Inflation Increment

2. The Direct Care Supplies and Other inflation increment is the facility's CMI times the Statewide Inflation Increment in Section 5.440.

Direct Care Supplies and Other Inflation Increment = CMI * Statewide Direct Care Supplies and Other Inflation Increment

Direct Care Supplies and Other Reimbursement Period Allowance (SORA) = Direct Care Supplies and Other Common Period Allowance (SplyCom) + Direct Care Supplies and Other Inflation Increment

The facility will receive the total of the Direct Care Direct Services Reimbursement Period Allowance and the Direct Care Supplies and Other Reimbursement Period Allowance.

3.129 Allocation by Level of Care

This allocation is done by dividing the Reimbursement Period Allowance by the facility's Case Mix Index prior to the 20% adjustment in Section 3.125, and multiplying the result by the Case Mix Weights in Section 5.420.

3.200 SUPPORT SERVICES ALLOWANCE

3.220 Method of Calculation

Allowable expenses associated with a facility's provision of dietary and environmental services shall be combined, and payment determined, according to the following modified cost formula:

P = Dietary and Environmental services payment allowance

E = Facility's actual allowable expenses for dietary and environmental services (per patient day) adjusted by a composite inflation/deflation factor applied to the common period. The inflation factors are listed in Section 5.320.

Emin = Expense at minimum occupancy,

E * Minimum Occupancy Factor in 3.030

T1 = Target 1 as described in Section 5.510

T2 = Target 2 as described in Section 5.510

I = Per patient day increment under 5.510

If Emin is less than T1,

P = Emin + I + (0.50 * (T1 - Emin))

If Emin is equal to or greater than T1, but equal to or less than T2,

P = T2

If Emin is greater than T2,

P = T2 + (0.05 * (T2/Emin) * (Emin - T2))

3.250 Administrative and General Services Allowances

3.251 Method of Calculation

Payment for allowable expenses associated with the facility's provision of Administrative and General services shall be determined according to the following formula:

P = Administrative services payment allowance

E = Facility's actual allowable expenses for administrative and general services (per patient day) adjusted by an inflation/deflation factor applied to the common period. Inflation factors are listed in Section 5.330.

Emin = Expense at minimum occupancy,

E * Minimum Occupancy Factor in 3.030

T = Per patient day Target under Section 5.551.

I = Per patient day increment under 5.551

If Emin is less than T,
 $P = E_{min} + I + (0.50 * (T - E_{min}))$
 If Emin is equal to or greater than T,
 $P = T + I$

3.300 FUEL AND OTHER UTILITY EXPENSE ALLOWANCE

3.310 Method of Computation

Fuel and other utility expense shall be determined as described below. Payment shall be determined by the following modified cost formula:

P = Fuel and utility payment allowance
 E = Facility's actual allowable expenses per patient
 per day for fuel and utilities as adjusted by
 component inflation/deflation factors to the
 common period. Inflation factors are listed in
 Section 5.340.
 Emin = Expense at minimum occupancy,
 E * Minimum Occupancy Factor in 3.030

T = Target expense for facility's location.
 See Section 5.610 for targets.

I = Inflation factor to adjust payment and expense
 to the payment rate year. (See 5.612.)

If Emin is less than the target
 Payment = $[E_{min} * I] + (0.50 * (T - E_{min}))$

If Emin is equal to or greater than the target
 Payment = $[T * I]$

3.340 On-Site Water and Sewer Plants

For facilities which have on-site water and sewer plants, costs associated with maintaining such operations will be included in the support services payment allowance, not the fuel and utilities payment allowance. For such facilities, the utility target will not be adjusted downward to reflect the absence of costs associated with the water and sewer functions, nor will the support services payment allowance be adjusted upward to reflect the presence of costs associated with the water and sewer functions.

3.360 Seasonal Cost Variations

If a facility's base cost report is not for a twelve-month period, the heating fuel and utility expense shall be adjusted for seasonal cost variations. Whenever possible, a twelve-month period for heating fuel and utility expense should be used with such expenses adjusted to the time period covered by the patient day count. If twelve months cannot be acquired, then heating fuel expenses should be adjusted to a twelve-month period based on heating degree days.

3.400 PROPERTY TAX ALLOWANCE

3.410 Tax-Paying Facilities

Allowable property tax expense shall be based on the tax due for payment by the provider (or the lessor of the building) in the calendar year in which the payment rate year begins times the minimum occupancy factor in Section 3.030. For example, a July 2002 payment rate will include the amount of the December 2001 property tax bill increased by the inflation factor in Section 5.700 to adjust payment and expense to the payment rate year. Alternative cost reporting may be allowed under provisions in Section 4.000.

3.420 Tax-Exempt Facilities

The property tax allowance for tax-exempt providers may include the cost of needed municipal services. For municipal service fees, the expense shall be the expense for municipal services provided to the facility in the calendar year prior to the beginning of the payment rate year as appropriately accrued to that period times the minimum occupancy factor in Section 3.030. The operating expense will be inflated/deflated to the common period by the support services inflation factor. Alternative cost reporting may be allowed under provisions in Section 4.000. The payment rate will include the inflated amount increased by the inflation factor in

Section 5.700 to adjust payment and expense to the payment rate year. For operating expenses incurred by the facility, the expense will be from the cost reporting period used for other payment allowances.

3.500 PROPERTY PAYMENT ALLOWANCE

3.510 General

The property payment allowance will be a per patient day amount based on: the equalized value of the nursing home; target amounts based on service factors established by the Department; and the nursing home's allowable property-related expenses. This allowance is intended to provide payment for ownership, and/or rental of land, land improvements, buildings, fixed and movable equipment and any other long-term, physical assets. The asset value of nursing homes acquired at nominal or no cost shall be allowed at the lesser of fair market value or net book value of the owner last participating in the Medicaid program. Depreciation life shall be at the greater of 20 years or balance of 35 years from date of construction. The minimum estimated useful life of used movable equipment will be 5 years. This life will be applied to the composite value of the acquired equipment.

3.520 Allowable Property-Related Expenses

Allowable property-related expenses include: depreciation, interest on plant asset loans, amortization of construction-related costs, amortization of bond discount and premium, lease and rental expenses, and property and mortgage insurance. These costs must be reported in accordance with generally accepted accounting principles (GAAP) and must be necessary for providing nursing home patient care.

The cost reports for the base cost reporting periods and alternative cost reporting periods, as defined in Sections 1.302 and 4.000, will be the source for the information used to determine allowable property-related expenses.

Allowable costs will be adjusted to reflect any limitation on the revaluation of capital assets or lease limitations required under Sections 3.522 or 3.523.

3.521 Maximum on Allowable Property-Related Expenses

Annual allowable property-related expenses will be limited to 15% of the equalized value of the facility.

3.522 Changes of Ownership

If a facility changes ownership on or after October 1, 1985, a change in valuation will be allowed the new owner of the facility. The new owner's valuation will be the lesser of the purchase price or maximum valuation. The maximum valuation is calculated by multiplying the sellers annual asset acquisition costs by year(s) of acquisition times the lesser of one-half of the percentage increase, measured over the same period of time, in the Consumer Price Index (CPI) for All Urban Consumers (United States city average) or the Dodge Construction Index (DCI) applied from the year(s) of acquisition to the date of the sale. The year(s) of acquisition is/are the year(s) the assets were purchased or constructed by the seller of the facility.

If either the seller or the buyer cannot support the individual assets acquired, the historic asset acquisition cost(s) and/or the date(s) of asset acquisition, the following procedure will be followed to impute the maximum allowable value related to capital assets:

1. The ending balance of the total capitalized historical cost of all depreciable assets, from the last available fiscal year cost report of the seller, will be the base value;
2. The ending balance of accumulated depreciation of all depreciable assets, from the same cost reporting period, will be divided by the reported depreciation expense (annualized, if necessary) to impute average years of ownership;
3. The lesser percentage of CPI or DPI described in the first paragraph of this Section 3.522 will be determined based on the imputed average years of ownership and applied to the base value of all assets acquired to calculate an initial maximum;
4. This initial maximum will be compared to 108% of the equalized value described in Section 3.531 below and the lesser value allowed as the maximum allowable value related to all assets.

Where no cost report information is available, the maximum allowable value will be 108% of the equalized value from Section 3.531.

If more than one nursing home is purchased at the same time, the purchase price of all property related assets will be allocated proportionately to all purchased assets based upon an independent uniform appraisal method chosen by the purchasing provider.

This section does not apply to changes of ownership pursuant to an enforceable agreement entered into prior to October 1, 1985.

The costs of acquiring the rights to licensed beds from another provider are non-reimbursable.

3.522(a) Expenses Associated with Change of Ownership Limited by Section 3.522

If a facility's valuation is limited under Section 3.522 the associated depreciation, amortization, and interest expenses will also be limited. Reported depreciation, interest and amortization expenses will be multiplied by the ratio of the above maximum to the actual purchase price to determine allowable expense. If the valuation of assets of the new owner are not limited to the maximum in section 3.522 actual costs will be allowed subject to section 3.520 allowability.

3.523 Lease and Rental Expense

1. Lease Maximum determination for on-going leases. If a facility was leased prior to the current cost reporting period, the maximum allowable lease expense for the current cost report period, will be limited to the lower of the actual lease payments or the total of the allowable lease expenses from the previous years cost reporting period multiplied by one-half of the percentage increase (as measured over the same period of time) in the Consumer Price Index for all Urban Consumers (United States City average).
2. Lease Maximum determination for previously owned but never leased. If a facility is leased during the current cost reporting period but was not previously leased, the allowable maximum lease expense will be determined by reference to the current owners year(s) of acquisition of the facility's fixed assets to the current cost reporting period. The year(s) of acquisition is/are the year(s) the facility was purchased or constructed by the owner. The lease maximum will be determined by: a) If the facility is still owned by the original provider that constructed the facility- divide the original cost(s) of construction/acquisition adjusted by one-half of the Consumer Price Index, by the original costs(s) of construction/acquisition; or b) If the facility was previously purchased - divide the allowable purchase price adjusted by one-half of the Consumer Price Index plus capital additions, by the allowable purchase price plus capital additions from the cost report used for rate setting prior to the lease (per Section 3.522). This ratio will then be applied to the allowable property expenses, related to the assets now leased, and that were included in rates effective June 30, 2002 to determine the maximum allowable property expense subject to number 5 below and Section 3.523.(a). The lower of actual or calculated maximum lease expense shall be used for determining the property reimbursement under Section 3.530.
3. Lease Maximum determination for new or replacement facilities. For new or replacement facilities that began operation in the cost report used for 2002-2003 rate setting, the lease expense paid is the maximum allowable for 2002-2003 subject to all other cost standards and formula limitations.
4. Lease determination for a sale and lease back. For purposes of this section, an unrelated party sale and lease back transaction will be limited by the percentage increase that would be applied if the facility had been leased prior to the base cost reporting period. The lease maximum shall be determined by applying one-half the increase in the CPI from the year of the sale to the allowed reimbursable property expenses for the assets that are now leased from the year before the sale.
5. General provisions of allowable lease determinations. This limitation will only apply to lease expense and other capital costs as of the date of lease inception. It will not apply to depreciation, interest, lease and rental or other property costs on assets, whether the lessee or lessor acquired the assets after lease inception, such as the purchase or leasing of new equipment or leasehold improvements.

If a facility is unable to provide adequate support of the dates of asset acquisition, the procedure under Section 3.522 for imputing average years of ownership may be applied.

Lease expense includes the actual payments required under the lease contract. Lease expenses determined under the capitalized lease method of Financial Accounting Standards Board Statement No. 13 will not be recognized.

The costs of acquiring existing leasehold rights are not allowable.

3.523(a) For leases existing prior to the cost report used for 2002-2003 rates, the limit calculated under this section will be increased for depreciation and interest expenses incurred by a lessor for leasehold improvements completed on or after July 1, 2002. The amount of increase will be calculated as if the lessee had made the improvements. This increase will be allowed only after a written agreement by the lessor has been received by the Department guaranteeing access to all records relating to the claimed expenses.

3.524 New Facilities, Replacement Facilities and Significant Licensed Bed Increases or Decreases on or after July 1, 2002

For new facilities licensed on or after July 1, 2002, and facilities with significant licensed bed increases or decreases on or after July 1, 2002 (as defined in Sections 1.305 and 1.304 respectively), the property payment allowance will be recalculated using the cost reporting periods and procedures described in Sections 4.300, 4.400, or 4.500.

The property payment allowance will also be recalculated when a facility has replaced a significant number of licensed beds. ("Replacement" is defined in Section 1.306.) (A "significant" replacement is defined as the replacement of the lesser of: (1) 25% of licensed bed capacity or (2) 50 beds.) When a significant replacement has occurred, the property payment allowance will be based on at least a six-month cost reporting period which begins within five months after the first of the month following licensure of the replacement bed area. The adjusted property payment allowance will be effective as of the date of licensure. No phase-in or start-up provisions will apply to property payment allowances for facilities receiving adjustments for replacement facilities.

3.525 Depreciation and Amortization

1. Amortized A & G expenses. Amortization of the costs related to acquiring financing (i.e., bond issuance costs, bond placement fees, and letter of credit fees) are not considered property-related expenses but are allowable expenses under the administrative and general component. Financing fees include such items as, but not limited to, finder's fees, credit checks, origination fees, appraisal fees, feasibility studies, and loan application fees. Amortization of such fees is allowable in A & G. Write off of the entire unamortized discount (premium) and unamortized fees associated with refinanced debt will be allowed as of the date of refinancing as recognized for cost reporting purposes.
2. Amortized property expenses. Amortization of bond discounts and premiums are to be considered an element of interest expense. Letter of credit fees related to a letter of credit used only as collateral for obtaining long term financing (bonds, mortgages, etc.) shall be allowed as property.
3. Depreciation expense. Depreciation expense must be calculated under a straight-line method over a useful life, consistent with generally accepted accounting principles (GAAP). Useful lives will be determined by reference to the useful lives guidelines published by the American Hospital Association.

3.525(a) Minimum Useful Life for Plant Assets

Depreciation for either the initial construction of buildings or building additions (including fixed equipment and land improvements) must be based on a minimum useful life of 35 years from the earlier of: 1) the date of initial licensure of the facility as a nursing home or other health care facility, or 2) the date of initial occupancy. Remodeling projects of existing licensed facilities will be depreciated according to American Hospital Association (AHA) guidelines for each of the individual components of the project. A minimum estimated useful life of 20 years will be applied to facilities purchased after July 1, 1988. New movable equipment will be depreciated according to AHA guidelines. The minimum estimated useful life for purchases of used movable equipment will be 5 years. This life will be applied to the composite value of the purchased equipment.

3.525(b) Expenses Directly Related to Establishing Units for Services to Ventilator Dependent Residents

A facility's additional expenses for depreciation and interest directly related to establishing a unit for ventilator dependent residents may be exempted from the limitations and maximums under Sections 3.500. "Directly related" means that the costs have been incurred solely as a result of creating this unit and the equipment acquired or remodeling performed benefits only this unit. Prior approval by the Department (i.e., Administrator of the Division of Health Care Financing) of the remodeling project or equipment acquisition is required. This adjustment is only available for projects completed after July 1, 1993.

3.526 Interest Expense

Generally, interest expense on loans for acquisition of nursing home plant assets and equipment is an allowable property-related expense. Interest expense must be reasonable and necessary to be considered allowable. "Necessary" means that the interest is incurred on a loan necessary to satisfy a financial need and for a purpose reasonably related to nursing home resident care. Allowable interest expense on debt incurred for the acquisition of land, land improvements, buildings, leasehold improvements, and fixed and movable equipment related to nursing home patient care is a property-related expense.

3.526(a) Basis for Allowable Interest Expense

Allowable interest expense is based on:

1. Proper accrual under Section 1.302;
2. Recognizable debt balances under Section 3.526(b);
3. A "systematic reduction of debt" under Section 3.526(c);
4. Financing terms that would be incurred by a "prudent buyer" at the time a debt is created; and
5. The net amount remaining after investment income is offset.

3.526(b) Recognizable Debt Balances

Interest expense will be allowed only on debts which:

First, are for the acquisition of the plant assets listed in Section 3.526 that are directly related to nursing home patient care;

Second, have been limited or allocated, if necessary, under Section 3.522; and

Third, are for the original asset acquisition plus the second & third cost report year after a loan has been taken out, we will add the amount of asset purchases to the assets purchased the first year of the loan to determine maximum financing allowed. The recognized debt balance will be adjusted when the additional assets flow through the aforementioned cost reports.

Fourth, do not exceed 110% of Equalized Value per Section 3.531(b).